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COST OF VA MEDICAL CARE TO INELIGIBLE PERSONS IS HIGH AND DIFFI--ETC(U)  
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AD A106588

BY THE COMPTROLLER GENERAL  
**Report To The Honorable William  
Proxmire, United States Senate**  
OF THE UNITED STATES

**Cost Of VA Medical Care To  
Ineligible Persons Is High And  
Difficult To Recover.**

(11) 2 JUL 82

(12) 43

During the 27-month period ended December 31, 1979, the Veterans Administration attempted to collect \$15 million from persons who had received medical care in VA facilities, but who were not eligible for VA benefits. VA recovered \$1.2 million of this amount and wrote off \$6.5 million as uncollectible.

A major cause of the problem involving ineligible persons is VA's policy of not denying medical care to persons pending positive determination of their entitlement to VA benefits. For many of the cases GAO reviewed, it took VA a long time to determine an individual's eligibility status. GAO found that once VA had provided care to ineligible persons, collection actions to recover the costs were generally unsuccessful.

GAO recommends that VA: (1) provide medical care to individuals whose entitlement to veteran benefits cannot be determined at the time of application only when their medical condition requires prompt medical attention; and (2) strengthen the eligibility determination process and collection of debts.

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COMPTROLLER GENERAL OF THE UNITED STATES  
WASHINGTON D C 20548

B-203318

The Honorable William Proxmire  
United States Senate

Dear Senator Proxmire:

Pursuant to your request, we have reviewed the extent to which the Veterans Administration has strengthened its administrative controls to preclude providing medical care to persons who were found not to be properly entitled to veteran benefits. This report points out that veteran medical benefits have been subject to abuse by ineligible persons and makes recommendations to the Administrator of Veterans Affairs to strengthen the agency's admissions and eligibility determination process and the collection of debts.

As requested by your office, we have not obtained agency comments on the matters discussed in the report.

As arranged with your office, we have limited distribution of the report to the Veterans Administration. Also, as arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Acting Comptroller General  
of the United States

Mr. Tolson	
Mr. E. A. Tamm	
Mr. Clegg	
Mr. Glavin	
Mr. Ladd	
Mr. Nichols	
Mr. Rosen	
Mr. Tracy	
Mr. Carson	
Mr. Egan	
Mr. Gurnea	
Mr. Harbo	
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Mr. Quinn	
Mr. Nease	
Miss Gandy	

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COMPTROLLER GENERAL'S REPORT  
TO THE HONORABLE WILLIAM PROXMIRE  
UNITED STATES SENATE

COST OF VA MEDICAL CARE TO  
INELIGIBLE PERSONS IS HIGH  
AND DIFFICULT TO RECOVER

D I G E S T

Veterans Administration (VA) medical benefits are vulnerable to abuse by individuals who seek care in VA facilities but who are not legally entitled to VA medical benefits.

Despite recommendations previously made by GAO in 1977 to improve eligibility determinations, VA has done little to prevent or minimize abuse of medical benefits by ineligible persons. GAO found that individuals who were not legally entitled to VA benefits received medical care in VA facilities before and after VA had determined that they were ineligible.

During the 27-month period ended December 31, 1979, VA attempted to collect \$15 million in costs incurred as a result of providing medical care to ineligible persons. It collected \$1.2 million and wrote off \$6.5 million of the remaining debts as uncollectible.

A major cause of VA's providing care to ineligible persons is its policy of not denying care to individuals pending positive determination of their legal entitlement to VA benefits. When VA medical centers cannot verify an individual's eligibility, they are to request assistance from VA regional offices. These offices verify military service data and/or make administrative decisions on whether individuals with "other than honorable" discharges qualify for veteran benefits. (See p. 7.)

For many of the cases GAO reviewed, VA took a long time to determine whether an individual is eligible for VA benefits. In some cases, incomplete and poorly maintained medical and administrative records at the centers reviewed contributed to this problem. Eligibility determinations were also delayed when VA regional offices failed to make administrative decisions or inform the medical centers that such decisions had been previously made. Furthermore, the medical centers did not always follow up

when the regional offices did not provide the requested information. (See pp. 8 to 13.)

Unlike information maintained by VA on eligible veterans, no centrally maintained file exists on individuals who had been determined ineligible for VA benefits. Presently, when a VA center becomes aware that it has provided medical care to an ineligible individual, other nearby VA centers are generally not notified. It is possible that ineligibles can receive care at other VA centers without being detected for extended periods of time. An improved information and notification system is needed to reduce the incidence of ineligible medical care and eliminate duplicative paperwork in determining eligibility. (See pp. 14 to 17.)

VA does not have an effective system for billing and collecting debts from ineligible persons who receive medical care. It also does not have an accurate account of all the care provided to ineligibles. In 61 of the 342 cases GAO reviewed, ineligibles were not billed for all of the medical care they had received. Furthermore, VA's billings were often sent to ineligibles months and sometimes years after they had received medical care.

VA has not taken collection actions on all of the moneys it is owed and, where such actions have been taken, it has failed to send out timely bills which has decreased the likelihood of its recovering the costs of care provided. (See pp. 18 to 20.)

For the most part, at the centers GAO reviewed, VA's collection actions to recover ineligible debts were unsuccessful. In total, it collected \$13,075, or 2 percent, of the \$693,349 of the debts resulting from care to ineligible persons whose cases GAO reviewed. At three VA centers, 74 to 92 percent of the debts were written off as uncollectible because the debtors could not be located or the cost of recovery exceeded the amount to be collected. (See pp. 21 to 24.)

VA is now exploring the use of its Target system--an on-line and regionalized data processing system for processing veteran claims for VA compensation, pension, and education benefits--to speed up

eligibility determinations for medical center use. GAO believes that use of VA's Target system is limited because VA's Beneficiary Identification and Records Locator Subsystem is not as complete and up to date as it should be for eligibility determinations. Therefore, its Target system may not significantly affect its ability to identify ineligibles in a more timely manner. (See pp. 28 to 31.)

Although recently enacted legislation should improve VA's agencywide debt collection activities, GAO believes this legislation may not significantly improve VA's collection of medical debts from ineligibles because many ineligibles are transient and have limited financial resources. GAO believes that VA should focus its attention on preventing or minimizing abuse of medical benefits by ineligibles through tighter admission policies. (See pp. 24 and 25.)

#### RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

To reduce the incidence of medical care and treatment to ineligible individuals, the Administrator should direct the Chief Medical Director to:

- Provide care to individuals whose eligibility cannot be verified at the time of application only if, upon examination, VA physicians determine that prompt medical care is needed. If there is no need for prompt medical attention, VA personnel should inform the individual that further care cannot be provided until his or her eligibility can be determined.

To expedite eligibility determinations, the Administrator should direct the Chief Benefits Director to:

- Update the Beneficiary Identification and Records Locator Subsystem records to the extent possible using available veterans' claims folders and keep them current.
- Direct regional offices when assisting medical centers to make certain they provide the centers with decisions on whether individuals with other than honorable discharges are entitled to VA benefits.

In addition, the Administrator should direct the Chief Medical Director to:

- Instruct medical centers to complete applications for medical benefits and records of examination, including all available service information and indications as to whether prompt medical care is needed.
- Require medical centers to actively follow up on their requests for eligibility determinations.
- Instruct medical centers to promptly bill ineligible individuals for all care provided.
- Establish a formalized system in which medical centers close to each other are notified when an individual has been determined ineligible for VA benefits.

GAO recommends also that the Administrator direct the Controller to improve the reporting and disposition of debts resulting from medical care provided to ineligibles.

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As requested by Senator Proxmire's office, GAO did not obtain comments on this report.



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# ABBREVIATIONS

BIRLS	Beneficiary Identification and Records Locator Subsystem
CP&E	compensation, pension, and education
DM&S	Department of Medicine and Surgery
DVB	Department of Veterans' Benefits
GAO	General Accounting Office
IRS	Internal Revenue Service
NPRC	National Personnel Records Center
VA	Veterans Administration
VADS	Veterans Assistance Discharge System

## CHAPTER 1

### INTRODUCTION

Senator William Proxmire requested, as Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, that we review (1) to what extent the Veterans Administration (VA) has provided medical care to persons who are not properly entitled to such care and (2) how effective VA has been in strengthening its administrative controls to preclude this type of abuse of the VA health care system.

In May and September 1977 we issued reports 1/ relating to this subject area and made recommendations to help improve the situation.

### BACKGROUND

VA's Department of Medicine and Surgery (DM&S) is responsible for ensuring complete medical care and services for eligible veterans, primarily through the largest centrally directed health care system in the Nation. In fiscal year 1980, VA provided care in 172 medical centers, 227 outpatient clinics, 92 nursing homes, and 16 domiciliaries. During the year 1.2 million veterans were hospitalized in VA centers. In addition, about 18.0 million visits were made for outpatient care--15.8 million to VA facilities and 2.2 million to private physicians on a fee-for-service basis. VA's fiscal year 1980 medical care budget was about \$5.8 billion.

VA's Department of Veterans' Benefits (DVB) is responsible for administering compensation, pension, and education benefits to veterans through 58 regional offices. These regional offices are responsible for assisting VA medical centers in determining veterans' eligibility for VA benefits. Within DVB, the Administrative Service is responsible for overseeing the maintenance of VA's Beneficiary Identification and Records Locator Subsystem (BIRLS)--a computerized identification index of over 35 million veterans and beneficiaries--and the Compensation and Pension Service is responsible for overseeing the adjudication activities within the regional offices.

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1/Letter report to the Director, VA Internal Audit, on treatment of ineligible veterans in VA hospitals (May 10, 1977).

Letter report to the Administrator of Veterans Affairs on treatment of ineligible veterans in VA hospitals (HRD-77-149, Sept. 19, 1977).

## ELIGIBILITY CRITERIA FOR VA MEDICAL CARE

Sections 610 and 612 of title 38 of the United States Code set forth the eligibility criteria for veterans seeking VA medical benefits. To be entitled to VA medical benefits, an individual must have served on active duty in the Armed Forces and have been discharged under conditions other than dishonorable. According to VA, honorable and general discharges qualify a veteran as eligible for benefits. Veterans with bad conduct discharges may or may not qualify depending upon an administrative decision made by VA, based on the facts of each case, as to whether the veterans were separated from service under dishonorable conditions or other than dishonorable conditions. Dishonorable discharges bar a veteran from VA benefits.

Eligible veterans are classified into two broad categories: those with service-connected disabilities and those without. Veterans with service-connected disabilities are afforded highest priority when seeking access to VA health care facilities and are eligible to receive inpatient and outpatient care.

Non-service-connected veterans who are at least 65 years old or who certify their inability to pay for care are eligible for hospital care only to the extent that VA facilities have the capacity to provide the services needed. They are also eligible for outpatient care to (1) prepare them for hospital care, (2) complete treatment incidental to hospitalization, or (3) obviate the need for hospitalization.

In addition to veterans legally entitled to VA benefits, section 611(b) of title 38 of the United States Code authorizes VA to provide medical care as a humanitarian service to individuals who are in need of immediate clinical attention for emergency medical problems. In such cases, VA is required to seek recovery of the costs of rendering such care and services at rates prescribed by the Administrator of Veterans Affairs.

## PROCEDURES FOR DETERMINING ELIGIBILITY

According to the DM&S Operations Manual, the procedures for determining eligibility for medical care are divided into two phases--the determination and verification of eligibility.

The determination of an individual's eligibility is made on the basis of information furnished when he/she applies for care. Individuals who have never been VA patients are required to complete the following items on VA form 10-10, "Application for Medical Benefits":

- name,
- home address,
- social security number,
- compensation and pension and disability data, and
- period of active military service.

The DM&S Operations Manual states that reasonable judgment be used in deciding that the information supplied qualifies an applicant for admission in accordance with the applicable VA regulations. It further states that such judgment be based on the premise that the information was given with full awareness on the part of the applicant of the penalties for making a fraudulent claim.

For individuals whose eligibility cannot be verified at the time of application through use of existing medical center records or information furnished by the applicant, the following steps are generally taken to verify eligibility for VA medical benefits:

1. A VA medical center first queries BIRLS, which can provide information on a veteran's claim folder location, military service dates, and character of discharge. If a veteran has a BIRLS record, a medical center can use this information to verify eligibility if the record shows that the veteran had received an honorable discharge and a satisfactory reason for separation.
2. If the BIRLS record shows an individual had received an other than honorable discharge, a medical center must submit a VA form 10-7131, "Exchange of Beneficiary Information and Request for Administrative and Adjudication Action," to the VA regional office indicated on the BIRLS record as having the veteran's claim folder or, if no BIRLS record exists, to that office having jurisdiction over the area in which the individual resides. Using form 10-7131, a medical center can request verification of a veteran's military service dates and type of discharge and/or an administrative decision as to whether a veteran with an other than honorable discharge is eligible for VA benefits.
3. When a VA regional office lacks sufficient information to verify an individual's eligibility, it uses VA form 60-3101, "Request for Information," to obtain military service information from the National Personnel Records Center (NPRC) in St. Louis, Missouri. If information supplied by NPRC indicates that a veteran received an other than honorable discharge, the regional office makes

a formal administrative decision as to whether the veteran's military discharge represents a bar to VA medical benefits.

4. The regional office notifies the VA medical facility of the final decision.

#### VA'S DEBT COLLECTION PROCEDURES

The Federal Claims Collection Act of 1966 (31 U.S.C. 951 et seq.) delegated to the Attorney General and to the Comptroller General the authority to prescribe standards for Federal agencies to follow when collecting debts owed to the Government. These standards are set forth at 4 CFR ch. 2.

Under VA policies and procedures on debt collections, each medical center is responsible for seeking recovery of the cost of medical care and services provided to individuals not legally entitled to such care. This function is carried out by the fiscal service at each VA medical center. When seeking recovery of debts, each center sends three collection letters to debtors at 30-day intervals. The first letter informs the debtor that he has the right to request that the debt be waived and that VA will consider a reasonable repayment plan. The second or third letter, depending on the amount of the debt and whether a compromise offer is warranted, informs the debtor that VA has the authority to accept a lesser amount in full settlement of the debt.

If there is no response to the second letter and the debt is \$600 or more, the VA center requests a credit report on the debtor when it sends out the third collection letter. If there is no response to the third letter, or the debtor requests a waiver or makes a compromise offer, the center, using the credit report or other financial status information, evaluates whether (1) the debtor is able to pay, (2) hardship factors exist on cases where waivers have been requested, (3) a compromise offer in settlement of the debt is acceptable, (4) further collection action should be suspended or terminated, and (5) the debt should be referred to the Department of Justice for further collection action. 1/

#### OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this study were to:

- Determine the extent to which the VA medical benefits are vulnerable to abuse by individuals who seek medical care at VA facilities which they are not legally entitled to receive.

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1/Before October 1979 VA referred certain debts to GAO for collection action. Since that time, VA refers such debts to the Department of Justice.

- Evaluate the adequacy of actions taken by VA to preclude or minimize providing medical benefits to ineligibles.
- Identify the costs of VA medical care provided to ineligibles and the extent to which VA has recovered such costs.
- Assist VA in developing an approach to minimize the ineligible problem and strengthening administrative practices now in place which affect eligibility determinations and debt collections.

We reviewed pertinent VA reports, regulations, and policies and interviewed officials at the VA Central Office in Washington, D.C., responsible for overseeing admission and debt collection activities at VA medical centers. We also interviewed officials at the Washington, D.C., VA regional office who determine eligibility for VA medical benefits for individuals living in the Washington, D.C., area. Onsite audit work at the Washington center was conducted on a limited basis and was primarily done to determine what records were available at VA medical centers relating to the determination of eligibility and the collection of debts due to ineligible medical care and treatment.

We obtained detailed information on 140 cases of ineligible medical care and treatment from six VA medical centers--Houston, Texas; Los Angeles (Wadsworth) and San Diego, California; Buffalo, New York; Hines, Illinois; and Lake City, Florida, VA medical centers. The cases reviewed represented the centers' total number of cases established during the quarter ended December 31, 1978. This quarter was chosen to allow time for the centers, which were giving us information in the fall of 1979, to have disposed of these debts in accordance with VA's debt collection procedures.

We also conducted onsite reviews of 202 cases of ineligible medical care and treatment at the Miami, Florida; New York, New York; and Washington, D.C., VA medical centers. The Miami and New York centers were selected because the outstanding balances for debts due to ineligible medical care and treatment were among the highest in the VA system during the quarter ended March 31, 1979--the most recent quarter for which statistics were available when we planned our fieldwork. The 202 cases reviewed represented nearly all of the centers' total number of cases outstanding during the quarter.

For the 342 cases established by the nine centers reviewed, we documented how long VA took to determine the eligibility status for 254 cases. The other 88 cases did not require determinations, as the individuals were known to be nonveterans when applying for

care and were treated for humanitarian reasons. We reviewed the billing and collection actions for all 342 cases.

We also reviewed an additional 114 cases of ineligible medical care and treatment which VA referred to GAO for collection action between January 1, 1978, and September 6, 1979.



## CHAPTER 2

### ADMISSION POLICY AND DETERMINATION

#### PROCESS CREATE A COSTLY PROBLEM

Providing medical care and treatment to individuals not legally entitled to such benefits has become a multimillion-dollar problem for VA. A major cause of this problem is VA's policy of not denying medical care and treatment pending positive determination of legal entitlement. Based on our review, VA medical benefits are vulnerable to abuse by ineligibles because VA takes a long time to determine that an individual is ineligible for veteran benefits. VA's efforts to preclude or minimize abuse of medical benefits by ineligibles have been ineffective. As a result, ineligibles received medical care in VA facilities before and after VA determined that these individuals were not entitled to veteran benefits.

#### IMPACT OF VA ADMISSION POLICY ON INELIGIBLE PROBLEM

During testimony before the House Veterans' Affairs Subcommittee on Special Investigations in May 1979 on VA's efforts to prevent fraud and abuse in VA programs, VA's Deputy Administrator stated it is VA policy that no veteran will be denied necessary medical care pending the determination of entitlement. The Deputy Administrator said that to do otherwise could cause delays in providing care to veterans legally entitled to receive such care.

While VA's policy has benefited many eligible veterans, we believe that it has also resulted in an "open door" policy for individuals not legally entitled to VA medical benefits. For example, for the 5-year period ended June 30, 1974, ineligible individuals owed VA \$11.5 million for medical care and services they had received in VA facilities. These debts were in addition to \$1.3 million of similar debts which had been outstanding at the beginning of fiscal year 1970, thus bringing the total amount of "ineligible" debts as of June 30, 1974, to \$12.8 million. Since that time, the rate of ineligible debts and their associated costs have grown considerably. For example, at the beginning of fiscal year 1978, VA carried over 3,800 debt collection cases resulting from care rendered to ineligibles from prior years, amounting to \$6.1 million. In addition, from October 1, 1977, to December 31, 1979, VA established 8,000 new debt collection cases totaling \$8.9 million. Thus, the total amount of money that VA was attempting to collect from ineligibles during this 27-month period was \$15 million.

According to VA systemwide reports, less than 40 percent of these debts involved individuals who received emergency treatment for humanitarian reasons. The remaining debts resulted from VA

providing medical care to individuals who were not medical emergencies and claimed to be or were presumed to be eligible veterans when they applied for care, but were later determined ineligible for VA medical benefits. A VA central office official told us that, during the above 27-month period, each of VA's 172 medical centers was attempting to recover moneys owed to VA by ineligibles for care they received in VA facilities.

ELIGIBILITY DETERMINATIONS  
ARE NOT TIMELY

For many of the cases reviewed, VA took a long time to determine whether individuals were eligible for medical benefits. We noted that many individuals had been hospitalized and/or treated as an outpatient more than once before VA determined that they were ineligible for such care. We also noted that many ineligible individuals received care in VA facilities on more than one occasion before VA took steps to determine their eligibility. In addition, we found that the medical and/or administrative records of ineligible individuals at the medical centers visited were incomplete and poorly maintained.

Time to determine eligibility  
of cases reviewed

For more than two-thirds of the 254 cases reviewed which involved eligibility determinations, VA took 30 days or more to determine that an individual was ineligible for medical care. In 34 cases VA took more than 1 year to determine an individual's eligibility status. The table below shows the time taken for VA's eligibility determinations for the 254 cases reviewed.

<u>Elapsed time</u>	<u>Number of cases</u>	<u>Percent of cases</u>
Under 1 month	76	30
1 to 6 months	103	41
7 to 12 months	29	11
Over 1 year	34	13
Unknown	<u>12</u>	<u>5</u>
Total	<u>254</u>	<u>100</u>

VA officials told us that more timely determinations cannot be made if military service information must be obtained from NPRC or administrative decisions regarding eligibility must be made for individuals that received other than honorable discharges.

For 32 of the 254 cases reviewed, military service information had to be obtained from NPRC. We were able to determine how long it took NPRC to respond to VA in 20 cases, as shown below.

<u>Elapsed time</u>	<u>Number of cases</u>	<u>Percent of total cases</u>
Less than 1 month	9	45
1 to 2 months	7	35
2 to 3 months	2	10
Over 3 months	<u>2</u>	<u>10</u>
Total	<u>20</u>	<u>100</u>

NPRC responded that, for many of these cases, it could not verify the individuals' military records. Given this information, many VA medical centers attempted to verify the individuals' military service by sending them letters, which requested them to provide proof of service within 15 to 30 days. Using these letters further increased the time to determine eligibility, particularly since most centers did not promptly declare the individuals to be ineligible when they failed to respond within the requested time period. For example, at the Lake City VA center we noted a time lag of several months between the date VA's St. Petersburg regional office notified the center that an individual's military service could not be verified and the date the center requested proof of service from the individual. The time lag was even greater between the date the center requested proof of service directly from the individual and the date the individual was formally declared ineligible. During our fieldwork, the Lake City center stopped sending such letters due to lack of response and billed individuals, enclosing a letter stating that, if they could supply proof of service, the bill would be canceled.

Among the 254 cases reviewed, only 18 (7 percent) required an administrative decision by VA as to whether an individual's military discharge represented a bar to VA medical benefits. The table below indicates the time VA took to make these decisions.

<u>Elapsed time</u>	<u>Number of cases</u>	<u>Percent of total cases</u>
1 to 2 months	5	28
3 to 4 months	5	28
5 to 6 months	2	11
8 to 9 months	1	6
Over 1 year	2	11
Unknown	<u>3</u>	<u>17</u>
Total	<u>18</u>	<u>a/100</u>

a/Does not add to 100 percent due to rounding.

For most of the 18 cases cited above, the eligibility determinations were further delayed by 1 to 4 months.

We did not review the records directly related to these decisions; therefore, we cannot comment on the reasonableness of the time required to make them. However, we noted one factor related to VA's administrative decision process which unnecessarily delayed eligibility determinations. In 18 of the 254 cases reviewed, VA regional offices had informed medical centers that certain individuals had "other than honorable" discharges but had not informed the centers whether the discharges represented a bar to medical benefits. In such cases the centers had to recontact the regional offices to determine whether the individuals were ineligible. We noted that, in 12 of these 18 cases, center records showed that an administrative decision had been previously made, and therefore was available to regional offices when they first responded to the centers. A Lake City center official told us that, in about 50 percent of the cases having "other than honorable" discharges, the center had to recontact regional offices to determine whether an individual's military discharge represented a bar to VA benefits. According to a Buffalo center official, regional offices seldom provide this information to centers unless specifically requested, because regional staff are unaware that centers must know whether an other than honorable discharge represents a bar to benefits before an individual can be declared ineligible and billed for any services rendered.

#### Other delays in determinations

In addition to delays previously discussed, eligibility determinations were also delayed in about 9 percent of the cases reviewed because VA regional offices (1) failed to respond to centers' requests for determinations or (2) responded that information had been requested from NPRC and the affected centers did not promptly follow up on their requests. In most cases, followup actions were made by medical centers only when individuals whose

eligibility was questionable had reapplied for care. For example, in one case the New York center first requested an eligibility determination on an individual when he initially applied for care in August 1972 and was later informed that service information had been requested from NPRC. Although the center had received no further information on this case, it did not take any followup action until January 1977, or over 4 years later, when the individual had been readmitted to the center for the third time. At that time the regional office informed the center that the individual was barred from VA benefits based on an administrative decision made in 1956--almost 16 years before the New York VA center first requested an eligibility determination.

In 10 of the 254 cases, we found no indication that the centers had resubmitted requests for eligibility determinations when regional offices failed to respond to their original requests. In these cases, attempts to determine eligibility were generally made through letters requesting proof of service directly from the individuals.

Fingerprinting the individual and requesting assistance in identification through the Federal Bureau of Investigation, which attempts to match the fingerprints with those on records from the various military services, was an additional step taken by four of the centers reviewed. However, this method of verifying military service data was used infrequently (in 7 percent of the 254 cases reviewed). Generally, most centers attempted to verify military service data through VA records before submitting fingerprints. For many cases in which this method was used, fingerprints were sent in more than 1 month after the centers had begun determining the individual's eligibility. We believe that this time lag is most likely the reason why this method was seldom used, because often the individuals had already been treated and released.

#### Care provided before eligibility determinations are initiated

Medical centers generally begin determining eligibility only after individuals have been hospitalized or placed in an outpatient program. For individuals found not to need care, the centers reviewed did not take any steps to determine their eligibility, even though they had been examined by one or more physicians and received diagnostic tests and/or medication.

Among the cases reviewed, we noted that 37 ineligible individuals had received some form of care before the centers took steps to determine their eligibility. Of these, 14 individuals were seen once as outpatients before they reapplied for care, at which time the centers took steps to determine their eligibility. However, 20 individuals were seen as outpatients more than once before the centers began to make eligibility determinations.

For example, one individual at the Hines center was seen as an outpatient 12 times before the center took steps to determine his eligibility. According to a Hines official, no effort was made to determine eligibility on individuals treated as outpatients and released the same day because the determinations for individuals placed in ambulatory care programs and released the same day would result in an overload of paperwork. We pointed out that, under this practice, ineligible individuals could receive care at the Hines center many times without ever being found ineligible and billed for services rendered. The official agreed that this was possible; however, he believed that, because most of these individuals were transients, they may "make the rounds" of other VA facilities in the Chicago area, rather than return to the Hines center.

In 3 of the above 37 cases, the New York and Miami centers did not attempt to determine the individuals' eligibility when they first applied for care even though these individuals were hospitalized. In one case an individual was admitted at the New York center in May 1977 and hospitalized for 163 days. The center did not take steps to determine this individual's eligibility until his second admission in October 1977. Another individual was hospitalized at the Miami center for 22 days in May 1974 and seen as an outpatient 12 times between June 1972 and July 1975 before the center started determining his eligibility when he was readmitted in February 1976. In a third case an individual was hospitalized at the Miami center in March 1977 for 21 days and in June 1977 for 9 days, and treated eight times as an outpatient between April 1977 and January 1978 before the center took steps to determine his eligibility upon his ninth outpatient visit in February 1978.

Ineligible persons receive  
multiple episodes of care  
while centers determine eligibility

Of the 254 cases reviewed, 108 individuals received outpatient and/or inpatient care at a VA center on more than one occasion while the centers were determining their eligibility. The extent of care provided to these individuals ranged from some individuals being treated on two occasions as outpatients to one individual making 59 outpatient visits and being hospitalized twice. While VA determined their eligibility, these 108 individuals received 319 outpatient treatments, or an average of about three visits per individual. In addition, they were hospitalized on 180 separate occasions, or an average of 1.7 admissions per individual. In total, these admissions accounted for 2,719 days of hospital care--an average of 15 days per admission per individual.

Center records not complete  
and poorly maintained

With few exceptions, the medical and administrative records of ineligibles at the centers reviewed were incomplete and poorly maintained.

Many application for medical benefits forms were incomplete. Information frequently missing included the applicant's service number, dates of military service, and type of discharge. This information is particularly important because some VA regional offices will not request information from NPRC without it.

In addition, we noted in many applications the examining VA physician failed to note whether an individual was admitted for hospital care as a medical emergency. Specifically, we found that, of the 1,067 episodes of care received by ineligible individuals whose cases we reviewed, VA physicians failed to note whether the individual's condition was considered a medical emergency in 713 episodes or 67 percent of the time. As a result, we could not determine whether these individuals were admitted for care as a humanitarian service.

In 22 of the cases reviewed, the individuals' medical and/or administrative records contained duplicative requests for eligibility determinations from VA regional offices. For example, in February 1977, the Houston center requested the Houston regional office to make an administrative decision on an individual's discharge. In July 1977 the regional office informed the center that the individual was barred from VA benefits. Nevertheless, on September 11, 1978, this individual was readmitted to the Houston center and another request for an eligibility determination was forwarded to the Houston regional office on September 21, 1978. The regional office responded on September 27, 1978, once again informing the center that the individual was barred from benefits. A similar situation occurred at the New York center when it forwarded a request for determination on August 11, 1977, and received a response on September 1, 1977, citing a VA decision barring the individual from benefits. In October 1977 this individual was readmitted to the center and another request was forwarded to the New York VA regional office, which responded in November 1977 that the patient was barred from benefits. Houston and New York center officials were uncertain as to why these situations occurred but believed it may have resulted from untimely filing of information the centers received from the regional offices. Whether these duplicative efforts were due to poor filing or center employees' failure to thoroughly review the file for eligibility information, the result was unnecessary paperwork being generated and, more importantly, VA medical care being provided to ineligible individuals.

ELIGIBILITY DETERMINATIONS  
ARE NOT EFFECTIVE

Once an individual is determined ineligible for medical benefits, VA has no central file which could help preclude or minimize ineligible individuals from "making the rounds" of VA medical centers. When a VA center learns that an individual is ineligible for VA medical benefits, it is required to notify the individual and the attending physician if the individual is still hospitalized and to discharge him or her as soon as medically possible. Additionally, the center is to indicate on the covers of the individual's administrative and medical records that he or she is ineligible and to mark the center's master locator file card with this fact.

Most centers in our review did not promptly notify individuals that they were ineligible for VA medical care. In addition, while most centers had marked the individuals' records and file cards to indicate their ineligibility and had notified them, ineligible individuals continued to be provided care.

No central file on  
ineligibles exists

Presently, when an individual is determined ineligible for VA medical benefits, only the center at which the individual received care is aware of this fact. Other nearby centers at which an ineligible individual may seek care are not generally notified unless the VA central office learns that an individual has received care at several centers. However, the VA central office only becomes aware of such individuals when contacted by center employees who suspect that an ineligible individual has received care at more than one center. VA has no established procedures which require that this information be reported; it is purely judgmental on the part of center employees.

Not notifying other centers in the system, and particularly those near the center at which ineligible individuals originally received care, makes it possible for such individuals to receive additional medical benefits to which they are not entitled. Under VA's policy of not denying care pending determination of eligibility, these individuals could seek care at a number of medical centers, be hospitalized or treated as outpatients, and be discharged before the centers learned of their ineligibility.

Several VA officials told us that many ineligible individuals are transient and that this problem is more prevalent in large metropolitan areas. Given these facts, we believe that it is not improbable that ineligible individuals have received care in more than one center, particularly in large metropolitan areas, without being detected for an extended period of time. For this reason, we believe that it would be beneficial for the VA central



office to notify all centers close to each other when individuals are found to be ineligible. Such notification could reduce the incidence of ineligible medical care and treatment and eliminate duplicative paperwork involved in determining eligibility.

#### Notification is not timely

In 218 cases reviewed in which VA centers had determined an individual's ineligibility, the individuals were notified by letter. However, 75 (or 34 percent) of these letters were dated more than 2 weeks after the individual had been determined ineligible for VA medical care.

Based on available records, 36 individuals had received no formal notification of their ineligibility, although 18 had been notified that they would be determined ineligible if they failed to provide proof of service. One center--Washington--was particularly remiss in notifying ineligible individuals. In the five cases reviewed at the Washington center which involved eligibility determinations, we found no indication in its records that the individuals had been notified of their ineligibility. In two of the five cases, the records contained memorandums to the attending physicians informing them that their patients were ineligible. In one case, there was a memorandum which indicated that a center employee was directed to notify the individual that he would be billed, but there was no indication that the employee did so. In two cases, one in which the records showed that the attending physician had been notified of his patient's ineligibility, we noted that the individuals were told upon discharge to return to the center for followup outpatient care.

#### Individuals treated after having been determined ineligible

Despite actions by medical centers to notify individuals of their ineligibility and to mark this fact on their records, our review showed that 90 individuals were provided care in VA medical centers after they had been found to be ineligible. In total, these known ineligibles received 268 episodes of outpatient care and 45 hospital admissions for 654 days of inpatient care. Using VA's billing rates at the time of our review, the cost of this care would be \$110,814.

The table below shows the range of care provided to these 90 individuals after they were found ineligible.

<u>Care provided</u>	<u>Number of cases</u>	<u>Percent of total cases</u>
1 outpatient visit	31	34
2 to 4 outpatient visits	13	14
5 to 10 outpatient visits	4	4
11 to 20 outpatient visits	3	3
Over 20 outpatient visits	2	2
1 admission	14	16
2 admissions	1	1
3 admissions	1	1
1 admission plus 1 or more outpatient visits	16	18
2 admissions plus 1 or more outpatient visits	<u>5</u>	<u>6</u>
Total	<u>90</u>	a/ <u>100</u>

a/Does not add to 100 percent due to rounding.

The following are examples of individuals who were known to be ineligible but were readmitted or received outpatient care:

--In one case at VA's Houston center, an individual was first seen for a drug dependency problem as an outpatient on August 13, 1973. Between that date and the date he was determined ineligible--March 8, 1978--he had made 1,151 outpatient visits and been hospitalized at the center for 1 day. After VA's ineligible determination, this individual made 23 additional outpatient visits. The total cost of the care rendered was \$34,385.

--In another case at the Houston center, an individual was first seen as an outpatient on July 6, 1976. Before he was determined ineligible on August 4, 1977, this individual had made 337 outpatient visits and been hospitalized at the center for 1 day in July 1976 and June 1977. After VA's ineligibility determination, he made 32 additional outpatient visits. The total cost of the care rendered was \$14,623.

--At the Miami center, one individual was admitted to the center for 6 days on December 13, 1975, readmitted for 1 day on December 24, 1975, and received outpatient care on December 26, 1975, before he was determined ineligible on January 9, 1976. After this determination the individual was readmitted to the center for 2 days in July 1976

and 11 days in August 1977 and was treated as an outpatient on four occasions in March 1976, September 1977, and October 1977. On only one occasion--the admission in July 1976--did a VA physician indicate that the individual required care on an emergency basis. The total cost of the care rendered was \$2,809.

--In a case at the New York center, an individual was hospitalized in August 1972 and readmitted to the center on June 21, 1973, after having been treated as an outpatient on June 16, 1973. On June 28, 1973, the center learned that the individual was ineligible for medical benefits based on an administrative decision dated November 16, 1972. However, this individual was hospitalized at the center for 11 days on February 9, 1976, and for 52 days on February 27, 1976. In addition, this individual was treated as an outpatient in August 1974. The total cost of the care rendered was \$9,796.

In addition to individuals being readmitted or treated as outpatients after having been determined ineligible, individuals in 44 cases we reviewed, including 12 patients who had been readmitted, were hospitalized at the time VA determined their ineligibility. According to medical records, these known ineligibles remained hospitalized from 1 to 155 days after the centers became aware of the individuals' ineligibility.

### CHAPTER 3

#### BILLING AND COLLECTION OF COSTS FOR TREATMENT NEED IMPROVEMENT

VA's efforts to bill and collect moneys owed by ineligible individuals who receive medical care at VA's expense need improvement. Based on our review, VA does not have an accurate account of the total costs associated with medical care provided to ineligibles. Many ineligibles were not billed for all of the care and services they received in VA facilities. Also, VA's billings for care rendered were not sent to ineligible individuals for months and sometimes years after they had received care. As a result, collection actions have not been taken on all of the moneys owed to VA, and where collection actions have been taken, the lack of timely billings has decreased the likelihood of VA recovering such moneys.

Although VA centers reviewed generally followed VA procedures for debt collections, their efforts to date have been generally unsuccessful in recovering ineligible debts and, as a result, many debts are written off as uncollectible.

#### BILLS DO NOT COVER ALL CARE RENDERED

VA charges a standard per diem rate for inpatient care, which includes all services, supplies, etc. At the time of our review, VA's per diem rate was \$151 for general medical and surgical centers and \$98 for psychiatric centers. In addition, VA charged \$45 for each outpatient visit.

In 61 of the 342 cases reviewed, ineligible individuals were not billed for all the medical care they received. In total, these individuals were not billed for 143 outpatient visits and 235 days of inpatient care. The total cost of this care using VA's billing rates would be \$41,920.

At the New York center we noted that no ineligible individuals were billed for outpatient visits. Among the cases reviewed at this center, 32 individuals who made 99 outpatient visits were not billed for care they received. Five individuals were treated as outpatients 5 or more times, with one patient receiving outpatient care 24 times over a 6-year period. The chief of the medical administrative service at the center told us that he did not consider the problem of medical care provided to ineligibles to be a high priority because the center was unable to collect many debts. He said that billing such individuals for all the care they received would take more time and effort from an administrative standpoint than it was worth.

We believe that ineligible individuals should be billed for all care received. Although collection on such debts may be limited, there is no chance of collecting if such individuals are not billed. Furthermore, based on our review, the cases which VA is more likely to collect involve smaller amounts, such as those in which individuals had made only one or two outpatient visits. In addition, the bills for ineligible care are the only record VA maintains on the cost of medical care being provided to ineligible individuals. Without accurate billings VA cannot account for the total cost of care provided to ineligible individuals.

#### BILLINGS ARE NOT TIMELY

VA procedures require that individuals found to be ineligible for medical care should be billed promptly. However, as shown below, in only 50 percent of the 342 cases at the nine VA centers reviewed were individuals billed within 1 month after they had been determined ineligible.

<u>Elapsed time</u>	<u>Number of cases</u>	<u>Percent of total</u>
Less than 1 month	172	50
1 to 3 months	103	30
4 to 6 months	16	5
7 to 9 months	5	1
10 to 12 months	1	3
Over 1 year	21	6
Unknown	<u>24</u>	<u>7</u>
Total	<u>342</u>	<u>a/100</u>

a/Does not add to 100 percent due to rounding.

For 34 of the cases referred to GAO in which the date of the ineligible determination was available, we noted that only 50 percent of the individuals were billed within 1 month after they were determined ineligible.

Because VA did not bill patients promptly after the determination of ineligibility and because the determinations were not timely, the bills were often sent to the individuals months, and sometimes years, after they had last been treated at the centers, as shown below.

<u>Elapsed time between date of last treatment and billing</u>	<u>Number of cases</u>	<u>Percent of total</u>
Less than 1 month	139	30
1 to 3 months	201	44
4 to 6 months	50	11
7 to 9 months	26	6
10 to 12 months	10	2
Over 1 year	24	5
Unknown	6	1
Total	<u>a/456</u>	<u>b/100</u>

a/Includes 114 cases referred by VA to GAO for collection.

b/Does not add to 100 percent due to rounding.

As shown above, ineligible individuals were not billed within 1 month of receiving VA medical care in about 70 percent of the cases reviewed. Furthermore, in 34 cases we noted that the bills covered treatment periods of 2 years or more. For example, in January 1978 the New York center billed an individual for \$2,704 for inpatient care received in October 1971, June 1976, and November 1977. In another example, the Miami center billed an individual in December 1977 for \$2,477 for 18 outpatient visits made between June 1972 and December 1976 and inpatient care provided in May 1974, February 1976, and July 1977.

VA and private collection agencies have reported that the likelihood of collection decreases as time passes. We believe the lack of promptness in billing ineligible individuals may contribute to the fact that little money is collected by VA.

COLLECTION ACTIONS VARIED:  
NONE HAVE BEEN EFFECTIVE

The centers reviewed varied in how closely they adhered to VA procedures on ineligible debt collection activities. Despite efforts by most centers to collect such debts, these efforts were generally unsuccessful. At the nine centers in our review, VA collected \$13,075 (or 2 percent) of the \$693,349 of debts resulting from all the ineligible cases reviewed. At three centers, most debts--ranging from 74 to 92 percent--were written off as uncollectible.

Varied collection actions

At the San Diego, Houston, Lake City, Buffalo, Los Angeles (Wadsworth), and Hines VA centers, we reviewed debts which had been established between October and December 1978. Usually, these centers had made a concerted effort to collect these debts, although no center consistently issued collection letters at 30-day intervals, as required by VA procedures.

The Miami and New York centers, which were reviewed because of their high outstanding balances for debts resulting from ineligible care, differed in the amount of effort expended to collect ineligible debts. For example, the Miami center created the position of "accounts receivable technician" with the sole responsibility for following up on debt collection actions. In contrast, at the other centers reviewed, agent cashiers handled this responsibility, along with such other responsibilities as handling the funds for hospitalized patients, reimbursing patients for travel expenses, and distributing employees' pay checks. Before employing this technician, the Miami center did little to collect outstanding debts. Although the center had generally sent the first collection letter in a timely manner, the second letter was often sent several months or years later. Sometimes the second collection letter was not sent until the recently established accounts receivable technician position was filled, resulting in time lags of over 4 years between collection letters. Since employing the technician, the center has generally complied with VA debt collection procedures by sending collection letters at 30-day intervals and requesting credit reports on individuals whose debts exceeded \$600.

Similar to the prior situation at the Miami center, the New York center exerted minimal efforts to collect debts resulting from ineligible medical care, some of which had been outstanding since 1970. In 62 (or 57 percent) of the cases reviewed, the center forwarded the first collection letter over a year after the individuals had been billed. In 27 cases where second letters were sent, the time lag between first and second letters ranged from 3 months to over 2 years. In 24 (or 22 percent) of the 108 cases reviewed, no collection letters had been sent.

The chief of the fiscal service at the New York center said that the center lacked qualified staff to effectively handle debt collections. Although she planned to obtain additional staff to improve followup on collection activities, the chief stated that, even if VA collection procedures were closely followed, the likelihood of recovering these debts would be doubtful and, in many cases, would probably cost VA more than the actual debts.

Collection efforts are  
not effective

Even though some centers attempted to collect the debts resulting from ineligible treatment, the debts we reviewed were collected in full in only 23 (or 7 percent) of the 342 cases. Twenty-two of these cases involved individuals who stated they were not veterans when they applied for care. Of these, 11 individuals were billed less than 1 month after they last received care at the center, which most likely improved the chances of collection. In addition, VA received partial payments or settled

the debts through compromise in 13 (or 4 percent) of the cases reviewed. In total, VA collected \$13,075 (or 2 percent) of the \$693,349 of debts resulting from all the ineligible cases reviewed. At three of the nine centers, most ineligible debts--ranging from 74 to 92 percent--were terminated. Generally, these debts were terminated because the centers had been unable to locate the debtors or collect a substantial amount from them or because the cost of recovery would exceed the amount collected.

A VA central office official told us that the centers' inability to locate debtors severely limits collection of these debts. He said that many debtors are not at the address they gave at the time they were treated at the centers and efforts to locate these individuals are limited to using phone directories, post office locators, and State divisions of motor vehicles. The official said that the Internal Revenue Service (IRS) used to provide address information to VA for debt collection pursuant to the Tax Reform Act of 1976, as amended (26 U.S.C. 6103(m)(2)). However, this practice was discontinued in 1977 because VA was providing these addresses to credit investigators, and IRS viewed such disclosure to be improper even though the investigators were using the data solely for debt collection purposes in preparing credit reports on debtors.

We noted that the Miami center requested credit reports on almost all debts over \$600 even though in many cases the debtor's correct address was unknown. Usually, the credit reports received served no meaningful purpose because the credit investigators responded that they had been unable to locate the debtor or provide any useful information on the debtor. As a result, the center generally terminated debt collection activities. The chief of the fiscal service at the Miami center said that he regretted having to terminate so many debts, but sometimes the center had no other alternative because of the difficulty to locate the debtors. He also said that it is easy for ineligible persons to receive care at VA centers and that these individuals seldom pay for the care received. He believes the centers should use collection agencies to try to recoup some of these debts, stating that collection agencies only charge for their services if they are successful in collecting the debts. This idea had been proposed to the VA central office by the fiscal officers in the Florida medical district, but the VA central office did not favor this action, stating that enabling legislation would be required before VA could use the services of collection agencies. (See p. 24.)

At four of the centers, most debts--ranging from 59 to 100 percent--remained outstanding during our review. For example, the Lake City center had not disposed of any debts we reviewed, even though in most cases the required collection letters had been sent and/or attempts to locate the debtor had failed. At the New York center all but one case reviewed remained outstanding even



though some of these debts had been established in 1970. The chief of the fiscal service stated that the center had given outstanding debts a low priority and had not closely monitored the collection of moneys owed by ineligible. The chief said that most outstanding debts would be terminated. According to a VA report reflecting the center's activity on these accounts during October to December 1979, the New York center terminated 64 of 120 debts resulting from ineligible medical care and treatment. The amount terminated--\$94,915--represented 29 percent of the center's total ineligible debts.

MOST DEBTS REFERRED  
TO GAO WERE UNCOLLECTIBLE

Of the 114 cases reviewed which had been referred to GAO for collection, 51 (or 45 percent) had been determined uncollectible. These debts, totaling \$283,652, represented 47 percent of the total debts reviewed. Most ineligible debts VA referred to GAO are terminated as uncollectible because the debtors are financially unable to pay them.

DISPOSITION OF INELIGIBLE  
DEBTS SYSTEMWIDE

The debts we reviewed represented only a small portion of the total debts established by VA for ineligible individuals who received medical treatment. For example, between October 1977 and December 1979, VA billed ineligible individuals for \$8.9 million. In addition, at the beginning of this period, outstanding debts totaled about \$6.1 million. The table below indicates the disposition of these debts as of December 31, 1979.

Summary of Dispositions Made by VA During the Period  
October 1, 1977, to December 31, 1979

	<u>Amount</u>	<u>Percent of total debts</u>
Debts outstanding as of October 1, 1977	\$ 6,124,527	41
Debts established October 1, 1977, to December 31, 1979	<u>8,936,383</u>	<u>59</u>
Total	<u>15,060,910</u>	<u>100</u>
Type of disposition:		
Collections	1,192,542	8
Waivers	545,975	4
Terminations	6,502,587	43
Write-offs due to compromise, bankruptcy, or death of debtor	78,847	1
Referrals to GAO	1,026,016	7
Suspensions	104,554	1
Total	<u>9,450,521</u>	<u>a/63</u>
Debts outstanding as of December 31, 1979	<u>\$ 5,610,389</u>	37

a/Does not add due to rounding.

As shown, VA's efforts to recover costs of care provided to ineligible individuals have not been successful in that VA collected only 8 percent of the moneys owed during the above 27-month period. Many of these debts--43 percent--were written off. For the reasons discussed earlier, any significant improvement in VA's ability to effect whole or partial recovery of ineligible debts appears unlikely. Furthermore, unless actions are taken to speed up the eligibility determination process so that ineligible individuals are identified at the time of application, any marked decrease in establishing additional debts appears doubtful.

#### LEGISLATION TO IMPROVE VA'S COLLECTION OF DEBTS

To improve the Federal Government's collection of debts, the Federal Claims Collection Standards were revised in March 1979 to direct Federal agencies to "develop and implement procedures for reporting delinquent debts to commercial credit bureaus." The standards were revised as a result of our February 1979 report 1/ on the effectiveness of debt collection activities of the Federal Government.

This report concluded that overall debt collection in the Federal Government could be improved by adopting certain private sector practices, such as reporting debts to credit bureaus. To assist VA's implementation of the revised standards, various bills were introduced in the 96th Congress authorizing VA to (1) release debtors' names and addresses to credit bureaus, (2) charge interest and administrative costs on delinquent overpayment accounts, and (3) take legal action, using its own resources, to recover delinquent debts. The House and Senate later passed legislation adopting these legislative recommendations, which was signed by the President on October 17, 1980.

While the above actions should greatly improve VA's collection actions on certain delinquent debts, such as educational assistance overpayments, they may not significantly affect VA's ineligible debt problem because:

--Debts resulting from ineligible treatment are not automated so that reporting of such debts to credit bureaus and attempting to control them would be a problem.

--According to VA officials, most debtors have little or no resources to repay.

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1/"The Government Can Be More Productive In Collecting Its Debts By Following Commercial Practices" (FGMSD-78-59, Feb. 23, 1979).

For these reasons we believe that VA's actions regarding the ineligible debt problem should be directed toward strengthening VA admission policies for individuals applying for medical care whose eligibility for VA benefits cannot be promptly determined at the time of application.

## CHAPTER 4

### SOME ACTION TAKEN TO ADDRESS

#### INELIGIBILITY PROBLEM--MORE ACTION IS NEEDED

Over the years VA has studied how to improve the timeliness of eligibility determinations and its management of ineligible debts. While recommendations made in these studies have generally been implemented, our review showed that they have not proven to be effective in preventing or substantially reducing the incidence of ineligible medical care and treatment or improving the collection of moneys owed to VA.

In addition to these studies, VA is exploring the use of its Target system--an on-line data processing system--to improve the timeliness of eligibility determinations. Because the data maintained in BIRLS is not up to date, we believe that the use of the Target system will not have much impact on the time VA takes to identify ineligibles applying for medical benefits.

#### STUDIES DEALING WITH THE DETERMINATION PROCESS

Since 1974, two VA task forces have studied the problem of providing medical care to ineligibles. These studies are briefly discussed below.

##### 1975 VA task force study

In July 1974 the Administrator of VA appointed a task force to study, among other things, VA's policies, procedures, and controls over the collection of debts resulting from hospitalization of ineligibles. In March 1975 the task force issued an internal report on its study results. According to the report, the task force was concerned with the time it took medical centers to obtain eligibility determinations from VA regional offices. The task force noted that, due to delays in determining eligibility, ineligible patients had been hospitalized for extended periods and sometimes two or three times before being determined ineligible. Although the task force recognized that many factors are involved in determining eligibility, it believed that the time required could be reduced considerably if medical centers were "more zealous" in their pursuit of eligibility information and regional offices placed a higher priority on these cases. Based on its findings, the task force recommended that DM&S and DVB undertake a joint study to identify and initiate operational and procedural changes to expedite the development and furnishing of eligibility information to medical centers.

The joint study was completed in early 1976. According to a February 17, 1976, internal VA memorandum, the study team concluded that the procedures at that time for developing and furnishing eligibility information to medical centers were "quite adequate." They believed that fast responses (within 48 hours) from BIRLS and timely followup between medical centers and the regional offices should eliminate unnecessary delays in verifying eligibility. The study team recommended that, since some centers had experienced delays in furnishing eligibility information, the Medical Administration Service at the VA central office request all centers to review their followup procedures and, where delays in regional offices' responses resulted in extended periods of ineligible hospitalizations, inform the Service so that corrective action could be taken.

#### 1977 VA task force study

In late 1977 VA established a task force to study and make recommendations for improving information exchanges between VA medical centers and regional offices. The task force was established in response to our May and September 1977 reports relating to the ineligible debts which had been referred to GAO by the Alexandria, Louisiana; Hines, Illinois; and Houston, Texas, VA medical centers. Based on our review of these debts, we reported that individuals were being readmitted after being declared ineligible and that the time to determine eligibility was excessive. We recommended that VA

- review and change admitting procedures to preclude readmission of persons previously determined to be ineligible and
- evaluate ways in which the time to determine eligibility could be reduced.

Responding to these reports, in addition to forming the task force, the VA central office notified all VA medical centers to expedite eligibility determinations in questionable cases and take steps to discharge and/or transfer patients determined ineligible. The centers also were requested to clearly annotate all locator files, administrative and medical records to avoid furnishing additional benefits to known ineligibles.

The task force was to evaluate the time required to make eligibility determinations, develop methods to reduce the volume of eligibility determination requests, and improve processing at regional offices and medical centers. Based on its evaluation, the task force recommended that

- followup requests for eligibility determinations be made by telephone rather than by submitting additional written requests,

- all medical centers establish a continuing education and review policy for making eligibility determinations, and
- current policy for obtaining information from the regional offices be reviewed.

As a result of these recommendations, all medical centers are now regularly reminded, through monthly nationwide conference calls, about medical administrative responsibilities in accentuating the efficient and effective flow of eligibility information between regional offices and medical centers. In addition, in July 1979 DM&S reissued a portion of its procedures manual, revising instructions for processing centers' requests for eligibility verification (form 10-7131), adding instructions on using BIRLS in lieu of form 10-7131, and requiring telephone followups on cases where regional offices have not responded within 30 days of the centers' requests.

However, these instructions only allow medical centers to use BIRLS as proof of eligibility if the BIRLS record shows that an individual had an honorable discharge and a satisfactory reason for separation. If the BIRLS record indicates a discharge was dishonorable or had been declared a bar to benefits, VA centers must still submit a form 10-7131. In addition, although the requirement for telephone followup may reduce the time taken to determine eligibility, providing 30 days for response may not significantly reduce the incidence of ineligible hospitalizations.

#### TARGET SYSTEM NOT EFFECTIVE IN EXPEDITING MANY ELIGIBILITY DETERMINATIONS

On several occasions, VA has pointed out that the implementation of the Target system throughout VA's regional offices should improve timeliness of eligibility determinations. Several officials stated that it would be beneficial for medical centers to have Target terminals to aid in determining eligibility--a theory which is presently being tested at the Washington VA medical center. While the Target system may expedite eligibility determinations on eligible veterans who have master records in the system, we do not believe it will reduce the time to identify many individuals who are not eligible for VA medical benefits unless BIRLS contains complete and up-to-date information.

#### Target's usefulness is limited

VA's Target system is an on-line and regionalized data processing system, which was developed to modernize the claims processing activities of VA's compensation, pension, and education (CP&E) benefits programs. According to VA officials, the system can be useful in determining a person's eligibility for VA medical benefits in that it makes BIRLS and master record information immediately available to the user through a computer terminal. However, not all

veterans have master records on-line in the Target system. Veterans who have never applied for CP&E benefits or have been disallowed or no longer receive C&P benefits have no master record. For these individuals the only source of information available from the Target system is through the interface with BIRLS, which does not have complete information on all veterans.

BIRLS became operational in 1972 when VA consolidated and computerized some 84 million card files which had been located in the VA central office and in VA regional offices. Basically, these card files contained limited information, such as name, claim number, and folder location for veterans who had claims folders. In February 1975 BIRLS was expanded to include an interface with the Veterans Assistance Discharge System (VADS)--a system which creates a record for each veteran upon discharge from the military service. When this interface went into effect, it created a BIRLS record for veterans who had been discharged since January 1973. In October 1975 the information provided to BIRLS by VADS was expanded to include not only the veteran's character of discharge and service dates but also the reason for the veteran's separation from service, which may preclude a veteran's eligibility for VA benefits even though his discharge was under other than dishonorable conditions.

BIRLS records can be useful in determining eligibility if they contain information on a veteran's reason for separation from military service and character of discharge, including whether the discharge had been reviewed and found to be a bar to VA benefits. However, this information is only available if BIRLS records had been created since 1975 or updated to include character of discharge and reason for separation or information on administrative decisions.

Since 1972 VA policies require that BIRLS records be updated at VA regional offices whenever new or additional information is provided on a veteran. However, we noted that these updates may not have included information about administrative decisions on discharges until January 1979 when regional offices were first instructed to include this information in BIRLS records.

One VA official told us that BIRLS updates are often not done because the general attitude within VA regional offices is that BIRLS is not reliable. Other VA officials told us that BIRLS is not a reliable source of information because

- BIRLS records were not always created through the VADS interface when veterans were discharged from the service because the military failed to send VA information on the veteran's discharge;

- BIRLS records could indicate that a veteran has no record when actually VA has full information on the veteran; and

--regional office staff are reluctant to use BIRLS data as the "last word" in determining eligibility, as the record could have been updated incorrectly or mistakes could have been made in creating the record.

To date, VA has not reviewed BIRLS to see whether the information in the system is as current as possible or agrees with the veterans' claims folders. According to a VA official, such a review would be a major undertaking.

To determine whether BIRLS was current and whether additional information on an individual's eligibility could be obtained through the Target system, we queried BIRLS and master records on a sample of individuals who had been found ineligible at the New York and Miami centers. Our sample included 21 individuals whose BIRLS records at the time the center requested them (between 1975 and 1978) contained incomplete service information or the service information contradicted that provided by the regional office to the centers' requests for determinations of eligibility. Generally, these individuals' BIRLS records had not been updated, and few had master records in the Target system.

Based on this limited sample and comments from VA officials, it appears that BIRLS is not as complete and current as it should be if it is used as a basis for eligibility determinations. Because these data are the only source of information readily available to VA centers through teletype transmission or the Target system on many veterans, we believe that efforts should be made to update BIRLS information.

#### Pilot test of Target in VA centers

Many VA officials believed it would be beneficial for VA to install Target terminals at VA medical centers. The former chief of the Medical Administration Service at the VA central office stated that, although the system would only provide significant information on veterans who had been recently discharged from the service or had previously applied for VA benefits, the centers would be less likely to admit a person if they knew at the time of application that he had no record identifying him as a veteran.

In January 1979 VA's Planning and Program Evaluation Office issued a report on its review of the admission/outpatient area in the VA health care system. Among other things, the report addressed the installation of Target system terminals in VA medical centers. The study group concluded that having the capability to identify ineligible persons before treatment would be a benefit derived from installing Target terminals. However, they stated that the number of patients treated and later found ineligible appears to be small,



thus, the potential savings from screening out ineligible persons would have to be weighed against the cost of expanding the system into the medical centers. Therefore, they recommended that a cost-effectiveness study be made to include establishing a pilot installation of a Target terminal in a center to determine its impact on the center's operation.

The Washington VA medical center was selected for the pilot test. The Target system terminals were installed at the center in February 1980 and became operational in March 1980. Unlike VA regional offices, the center will not have the capability to update BIRLS or add information to the master record through the terminals. The terminals will be used solely to permit the center to gain direct access to BIRLS and master record information. VA officials believed that inquiry into BIRLS and C&P master records would be useful, but that education records would not contain relevant information for the pilot test. We believe education master records could be useful in the experiment if these records identify veterans who have been disallowed benefits due to ineligibility.

EFFORTS TO IMPROVE MANAGEMENT  
OF MEDICAL ACCOUNTS RECEIVABLE  
ARE NOT EFFECTIVE

Based on VA's March 1975 task force recommendations, the VA central office created a quarterly report on medical accounts receivable for the VA central office's and medical centers' use in monitoring ineligible debts. We found these reports were not accurate and served little use as a management tool.

VA task force review  
of accounts receivable management

VA's March 1975 task force reported that the medical centers' efforts to collect debts resulting from ineligible medical care and treatment were poor. The report pointed out that many ineligible individuals were unemployed, had no source of income, or had no fixed address and were difficult to locate. Therefore, the report noted that the probability of collection often is remote and many should be terminated. However, the report noted that many centers were suspending collection actions rather than terminating debts or referring them to GAO for collection. The report also noted that, although the debts established increased 39 percent from fiscal year 1970 through fiscal year 1974--an increase attributed to increasing per diem rates for hospital care--outstanding debts had increased about 94 percent over the same period. According to the report, the increase in outstanding debts indicated that centers were not disposing of them in a timely manner.

In addition, the task force noted that data in VA's general ledger accounts--the sole source of medical accounts receivable information--were insufficient to permit the VA central office and

center management to properly evaluate the status of medical accounts receivable. The task force recommended that a special one-time report be completed by medical centers as to the number, amount, age, and status of debts resulting from ineligible hospitalization. Based on the findings of this report, the task force recommended that a recurring report, preferably on a quarterly basis, be designed for management's use in monitoring medical accounts receivable.

Actions taken on task  
force recommendations

In July 1975 each VA center was directed by the VA central office to review its outstanding medical accounts receivable and to bring all accounts to a current status by immediately taking all required collection and disposition actions. These accelerated collection efforts were to be completed no later than October 31, 1975. Debts remaining outstanding were to be the subject of the one-time report, which was to be completed by November 14, 1975. This report was to identify the number and amount of outstanding debts as of October 31, 1975, resulting from ineligible and emergency hospitalizations. Further, the centers were advised that they would be subsequently informed as to how to prepare the recurring quarterly report.

Instructions for the new quarterly report were published in May 1976, and the first report was issued for the quarter ended June 30, 1976. In this report debts resulting from providing care to ineligible persons are categorized as "ineligible hospitalization or treatment" when a patient is presumed eligible but later found ineligible or as "emergency hospitalization" when the care is provided on a humanitarian basis. The report indicates, by medical center and in total, the number and dollar amount of debts outstanding at the beginning of the quarter as well as the number and dollar amounts of debts established during the quarter in each category. The report also indicates the disposition (collections, waivers, terminations, and referrals to GAO) of the total debts made during the quarter and total outstanding debts at the end of the quarter after these dispositions.

Quarterly report inaccurate  
and not used effectively

Our examination of the quarterly reports for all VA centers for each quarter between December 31, 1977, and December 31, 1979, showed that these reports were out of balance, i.e., the total dispositions plus the amount outstanding at the end of the quarter did not equal the debts established plus those outstanding at the beginning of the quarter. For ineligible debts, the amount that the quarterly reports were out of balance ranged from \$12,731 to \$473,370 for the period ended September 30, 1978, and September 30, 1979, respectively.

Furthermore, the amount of the medical accounts receivable identified in the reports could not be balanced to the general ledger account--the sole source of medical accounts receivable information before the quarterly report was created.

Although the information in the report is not completely accurate, the report with improvements could serve as a useful management tool to monitor the establishment and disposition of debts resulting from care being provided to ineligibles. However, the report is presently distributed to only the Finance Service and Reports and Statistics Service within the VA central office. No one within DM&S--which has overview responsibility for the administration and management of medical center operations--is provided a copy.

Within the Finance Service at the VA central office, the report has been used since the second quarter of fiscal year 1979 to prepare a systemwide summary, which shows the medical accounts receivable in total and compares the total to that reported in the previous quarter. However, the Finance Service does not review the quarterly reports on a center-by-center basis to identify those which are not actively disposing of their debts. In reviewing the reports for the first two quarters of fiscal year 1979, over 20 medical centers had reported no dispositions during both quarters. None of the centers had been contacted regarding this problem.

Finance Service officials stated that the Service should be analyzing the reports and initiating corrective actions within the VA system. However, they stated that such an analysis is not undertaken because of time and staff limitations and the fact that medical accounts receivable are considered a low priority within the Service.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### CONCLUSIONS

VA medical benefits are vulnerable to abuse by individuals who seek medical care in VA facilities but who are not legally entitled to medical benefits. During the 27-month period ended December 31, 1979, VA pursued collection of \$15 million of debts from ineligible individuals who received medical care in VA facilities. Of this total, VA collected about \$1.2 million and wrote off \$6.5 million as uncollectible. Although recent legislation should improve VA's agencywide debt collection activities, significant improvement in VA's ability to effect whole or partial recovery of ineligible medical care debts appears unlikely. Similarly, any marked decrease in the rate of establishment of ineligible debts is questionable, unless actions are taken to significantly shorten the time VA takes to determine an individual's eligibility for medical benefits.

A major cause of VA's ineligible problem is VA's policy of not denying medical care to individuals pending determination of entitlement. Recognizing that this policy has benefited many eligible veterans, it has also resulted in an "open door" policy for individuals not legally entitled to VA benefits. It takes VA a long time to determine that an individual is not eligible for medical benefits. To date, VA's efforts to prevent abuse of medical benefits by ineligibles have been largely ineffective. As a result, many ineligible individuals receive medical care in VA facilities before and after VA determines that they are ineligible for VA benefits.

VA is exploring the use of its Target system to speed up eligibility determinations. Based on our review, the usefulness of the Target system is limited because BIRLS does not have complete and/or up-to-date information on all veterans. Therefore, we believe that the Target system may not have any significant impact on VA's problem of identifying ineligibles in a more timely manner.

With few exceptions, the medical and administrative records of ineligibles at the centers reviewed were incomplete and poorly maintained. In several instances, poorly maintained records contributed to known ineligible individuals receiving VA medical benefits. In 67 percent of the 1,067 episodes of care received by ineligibles whose cases we reviewed, VA physicians failed to note whether the individuals were admitted for care because of a medical emergency. Sometimes poorly maintained records resulted in duplicative requests being made to VA regional offices for eligibility determinations when information already existed at the centers that certain individuals were ineligible for VA benefits. Also, eligibility determinations were delayed because VA regional offices had

informed medical centers that certain individuals had "other than honorable" discharges but had not informed the centers as to whether the discharges represented bars to VA benefits. Furthermore, applications for medical benefits were not completed in full, and as a result, eligibility determinations were delayed. In addition, VA medical centers were not actively following up with regional offices that had not responded to centers' requests for eligibility determinations.

Unlike information maintained by VA on eligible veterans, no central file is maintained on ineligibles, which could prevent or minimize abuse of VA medical benefits by such individuals. Presently, when a VA medical center learns that it has provided medical care to an ineligible, the center does not notify other nearby centers or the VA central office. Accordingly, it is possible that ineligibles can gain access to other VA facilities (particularly those nearby) and receive medical care for extended periods of time without being detected.

VA does not have an effective system for billing and collecting debts resulting from medical care provided to ineligibles. In addition, VA does not have an accurate account of all the costs associated with medical care provided to ineligibles. In many cases we reviewed, ineligibles were not billed for all of the care received in VA facilities. Furthermore, VA's billings for medical care provided to ineligibles were sent to them months, and sometimes years, after they had received care at VA's expense. As a result, collection actions have not been taken on all of the moneys owed to VA and, where collection actions have been taken, the lack of timely billings has decreased the likelihood of VA's efforts to recover such moneys.

Overall, the collection actions taken to recover ineligible debts at the centers reviewed were unsuccessful. Although most centers reviewed generally followed VA debt collection procedures, most debts were written off as uncollectible. In total, VA collected only \$13,076, (or 2 percent) of the \$693,349 of debts resulting from all of the ineligible cases we reviewed. At three of the nine centers reviewed, 74 to 92 percent of the debts were written off as uncollectible. Generally, these debts were written off because the centers were unable to locate the debtors or collect a substantial amount from them or because the cost of recovery would exceed the amount collected.

Recently enacted legislation should improve VA's agencywide debt collection activities. However, this legislation may not significantly affect VA's ineligible debt problem. In our opinion, VA's actions regarding the provision of medical care to ineligibles should be directed toward strengthening VA's admission policies for individuals applying for care whose legal entitlement for VA benefits cannot be promptly determined.

RECOMMENDATIONS TO THE  
ADMINISTRATOR OF VETERANS AFFAIRS

To reduce the incidence of medical care and treatment to ineligible individuals, we recommend that the Administrator direct the Chief Medical Director to:

- Provide care to individuals whose eligibility cannot be verified at the time of application only if, upon examination, VA physicians determine that prompt medical care is needed. If there is no need for prompt medical attention, VA personnel should inform the individual that further care cannot be provided until his or her eligibility can be determined.

To expedite eligibility determinations, we recommend that the Administrator direct the Chief Benefits Director to:

- Update BIRLS records to the extent possible based on available veterans' claims folders and keep them current.
- Direct the regional offices when assisting medical centers to make certain that they provide the centers with decisions on whether individuals with other than honorable discharges are entitled to VA benefits.

In addition, the Administrator should direct the Chief Medical Director to:

- Instruct medical centers to complete applications for medical benefits and records of examination, including all available service information and indications as to whether prompt medical care is needed.
- Require medical centers to actively follow up on their requests for eligibility determinations.
- Instruct medical centers to promptly bill ineligible individuals for all care provided.
- Establish a formalized system in which VA medical centers close to each other are notified when an individual has been determined ineligible for VA benefits.

To better manage debts resulting from ineligible hospitalization, we also recommend that the Administrator direct the Controller to:

- Reconcile the quarterly report on medical accounts receivable to insure it agrees with the general ledger account.
- Analyze the quarterly report periodically to identify and take corrective actions on centers which are not disposing of debts promptly.
- Provide a copy of the reconciled report to DM&S for analysis to identify and/or take corrective actions on an as-needed basis.

